STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A DUILI DIDIC	01	COMPLETED	
1		155042	A. BUILDING B. WING		11/09/2012	
			_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				OLD BRUCEVILLE RD BOX 136		
WILLOW MANOR				ENNES, IN 47591		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
K0000						
	A Quality Assur	ance Walk-thru Survey	K0000			
	was conducted b	by the Indiana State		Willow Life Safety POC 2012		
	Department of H	Health.				
	1			D. c. basitting the england		
	Survey Date: 11	1/09/12		By submitting the enclosed material we are not admitting	tho	
	Sarvey Bate. 11	1/03/12		truth or accuracy of any specif		
	Facility Normalism	000016		findings or allegations. We		
	Facility Number			reserve the right to contest the	е	
	Provider Number: 155042 AIM Number: 100291500 Surveyor: Dennis Austill, Life Safety			findings or allegations as part	of	
				any proceedings and submit		
				these responses pursuant to d		
				regulatory obligations. The fa	cility	
	Code Survey Su	pervisor		requests that the plan of correction be considered our		
	At this Quality Assurance Walk-thru survey, Willow Manor was found not in			allegation of compliance effec	tive	
				December 8, 2012 to the Life		
				Safety Code Recertification		
				Survey conducted on Novemb	per	
	compliance with 410 IAC 16.2-3.1-19(ff).			9, 2012		
	This one story facility was determined to			кооо		
	be of Type V (0	00) construction and fully		It is the practice of Willow Manor		
		ept for where noted in		to assure that the regulations		
	_	cility has a fire alarm		related to sprinkler coverage is in		
	system with smoke detection in the corridors, spaces open to the corridors and			compliance.		
				The correction action taken for		
	, · ·	*		those residents found to be affecte	d	
	hard wired smoke detectors in 108 resident rooms. The facility has a capacity of 170 and had a census of 134 at the time of this visit.			by the deficient practice include:		
				There are no specific residents identified. Please see under system	ne l	
				implemented to assure compliance		
				with this tag.		
				Other residents that have the		
	The facility was	found not in compliance		potential to be affected have been		
	I =	regard to sprinkler		identified by:		
		compliance in regard to		Potentially all residents could be		
				effected. Please refer to systems		
	smoke detector coverage.		1	implemented to assure compliance		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Page 1 of 6 State Form Event ID: JIMS21 Facility ID: 000016 If continuation sheet

TITLE

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155042		(X2) MULTIPLE CO A. BUILDING B. WING	01	COMPLETED 11/09/2012				
NAME OF PROVIDER OR SUPPLIER WILLOW MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE COMPLETION			
	customary acces noted in K-9999 facility services three detached e where noted in k was an enclosed storage of landso minibarn used fo waste and a woo employee smoki	the residents have s were not sprinklered as . All areas providing were sprinklered, except xterior buildings and X-9999. One building metal carport used for caping equipment, a wood or storage of biohazardous d shed used as an ng area. Robert Booher, Life Safety dical Surveyor on 11/13/12.		with this tag. The measures or systematic changes that have been put in place to ensure that the defici practice does not recur include. The awnings identified at the rentrance, D-Hall entrance, and F-Hall entrance has been remorated to a sprinkler installed to assiful coverage of the room. The beauty shop closet has had sprinkler installed. The detached smoking area has been closed with no smoking allowed in the building until a sprinkler is installed. The corrective action taken to monitor performance to assur compliance through quality assurance is: Proper sprinkling of the building be monitored as part of the preventive maintenance review the quarterly QA meetings. The Maintenance Director, or designing sprinklers are in place and functioning properly in the required areas. Any identified issues wi immediately addressed. The Administrator, or designee, will review the preventive mainten documentation quarterly for compliance with recommendation as needed. The date the systemic changes be completed: December 8, 2012	ent e: main I the oved. has ure d a s e may will w at ue gnee, g that uired II be II mance tions			

State Form Event ID: JIMS21 Facility ID: 000016 If continuation sheet Page 2 of 6

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/27/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155042		(X2) MULTIPLE CO A. BUILDING B. WING	COMPL	(X3) DATE SURVEY COMPLETED 11/09/2012			
NAME OF PROVIDER OR SUPPLIER WILLOW MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591				
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON DBE PRIATE	(X5) COMPLETION DATE	

State Form Event ID: JIMS21 Facility ID: 000016 If continuation sheet Page 3 of 6

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 01			COMPLETED		
155042		B. WING			11/09/2012		
			B. WII.		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					LD BRUCEVILLE RD BOX 136		
WILLOW MANOR			VINCENNES, IN 47591				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		**************************************		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
K9999							
	State Findings		K99	999	К9999		12/08/2012
			123333		It is the practice of Willow Manor		
	3.1-19 ENVIRO	NIMENT AND			to assure that the regulations		
					related to sprinkler coverage is in		
	PHYSICAL STA	ANDAKDS			compliance.		
					The correction action taken for		
		Ith facility licensed under			those residents found to be affected	d	
	16-28 and this ru	lle must do the following:			by the deficient practice include:		
		matic sprinkler system			There are no specific residents		
	installed throughout the facility before				identified. Please see under system	s	
	July 1, 2012.				implemented to assure compliance		
					with this tag.		
	(2) If an automatic sprinkler system is not				Other residents that have the		
	installed throughout the health care				potential to be affected have been		
	facility before July 1, 2010, submit before				identified by:		
	July 1, 2010 a plan to the department for				Potentially all residents could be		
	completing the installation of the				effected. Please refer to systems		
					implemented to assure compliance		
	automatic sprinkler system before July 1, 2012.				with this tag.		
					The measures or systematic		
	(3) Have a battery operated or hard-wired				changes that have been put into		
		n each resident's room			place to ensure that the deficient		
	before July 1, 2012.				practice does not recur include:		
					The awnings identified at the main		
	This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to provide appription.				entrance, D-Hall entrance, and the		
					F-Hall entrance has been removed.		
					The C/D hall medication room has		
					had a sprinkler installed to assure		
	facility failed to provide sprinkler				full coverage of the room.		
	coverage throughout the facility before				The beauty shop closet has had a sprinkler installed.		
	July 1, 2012. This deficient practices				The detached smoking area has		
	could affect any occupant of the facility.				been closed with no smoking		
	Findings include:				allowed in the building until a		
					sprinkler is installed.		
					The corrective action taken to		
	Raged on observe	ation with the			monitor performance to assure		
	Based on observation with the						

State Form Event ID: JIMS21 Facility ID: 000016 If continuation sheet Page 4 of 6

		IDENTIFICATION NUMBER: 155042	A. BUILDI B. WING			COMPLETED 11/09/2012		
NAME OF PROVIDER OR SUPPLIER WILLOW MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	between 12:00 p following was not a. The main entre entrances were compared awnings exceeding were attached to sprinkler coverage during the time of Maintenance Superinkler coverage the facility lacked indicating the fall inherently flame b. The beauty should be the time of observation of the time of observation of the complete coverage that the complete coverage complete coverage that the complete coverage is the time of observation, lack the complete coverage is the time of observation, the acknowledged the coverage is the complete coverage is the coverage in the complete coverage is the coverage in the coverage in the coverage is the coverage in the coverage in the coverage is the coverage in the coverage in the coverage is the coverage in the coverage in the coverage in the coverage in the coverage is the coverage in the coverage	rance, D hall and F hall overed with fabric ing four feet in width that the building and lacked ge. Based on interview of observation, the pervisor acknowledged didocumentation oric material was retardant. The pervisor and the C & D room lacked complete ge. Based on interview at evation, the Maintenance owledged the beauty shop prinkler head and the C & on room had one at would not provide ge for the room. The provide ge for the room of th			compliance through quality assurance is: Proper sprinkling of the building will be monitored as part of the preventive maintenance review at the quarterly QA meetings. The Maintenance Director, or designee, will be responsible for assuring that sprinklers are in place and functioning properly in the required areas. Any identified issues will be immediately addressed. The Administrator, or designee, will review the preventive maintenance documentation quarterly for compliance with recommendations as needed. The date the systemic changes will be completed: December 8, 2012			

State Form Event ID: JIMS21 Facility ID: 000016 If continuation sheet Page 5 of 6

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/27/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155042	(X2) MULTIPLE CO A. BUILDING B. WING	01	COM	PLETED 19/2012		
NAME OF PROVIDER OR SUPPLIER WILLOW MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	.D BE	(X5) COMPLETION DATE		

State Form Event ID: JIMS21 Facility ID: 000016 If continuation sheet Page 6 of 6